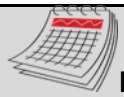
East London NHS
NHS Foundation Trust

# Newham Health Team for Adults with Learning Disabilities Referral Form

**Please complete all sections of this form as this will aid us to process your referral promptly.**

|  **Client Details:** | | | |  **GP Details:** | |
|---|---|---|---|---|---|
| **Title:** | | **Gender:** | Male ☐ Female ☐ | **Name:** | |
| **First Name:** | | | | **Address:** | |
| **Surname:** | | | | | |
| **Address:** | | | | **Telephone No:** | |
| **Telephone No:** | | | |  **Referrers Details:** | |
| **Date of Birth:** | | **Age:** | | **Name:** | |
| **NHS No:** | | | | **Designation:** | |
| **Language:** | | | | **Organisation:** | |
| **Interpreter Required:** | Yes ☐ No ☐ | **Advocate Required:** | Yes ☐ No ☐ | **Contact Details:** | |
| **Ethnicity:** | | | |  **Date:** | |
| **Religion:** | | | | | |

**We are a team composed of health professionals who work with adults with learning disabilities and complex health needs, who are unable to access mainstream health services.**
Please note, the following individuals would not be eligible for our service:

- × Client has a learning difficulty e.g. dyslexia, dyspraxia
- × Client has an acquired brain damage/ injury in adulthood (i.e. an injury NOT acquired before the age of 18)
- × Client who has a physical disability but not a learning disability
- × Client who has sensory impairment (visual or hearing) only

 **Referral Details:**

**Please tick the service(s) you wish to refer in to:**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Art Therapy | ☐ | Clinical Psychology | ☐ | Community Nursing | ☐ | Consultant Psychiatry | ☐ |
| Occupational Therapy | ☐ | Physiotherapy | ☐ | Speech & Language Therapy | ☐ | | |



November 2016

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**Reason for referral and presenting problems i.e. what unmet health need(s) does the client have?**
(include views of the client, carer & referrer**):**


**Learning Disability Details:**
**Please provide any supporting evidence and attach any relevant reports)**

**What evidence is there that the person you are referring has a learning disability?**
Please attach a report or letter with a diagnosis, or if this is not available, complete the boxes below

| **Activities** (Can / do they) | ✓ | x | **Memory** (Can they remember) | ✓ | x | **Life experiences** (Have / do they) | ✓ | x |
|---|---|---|---|---|---|---|---|---|
| Read | ☐ | ☐ | Significant things about themselves | ☐ | ☐ | Attended a special school | ☐ | ☐ |
| Write | ☐ | ☐ | Where they live | ☐ | ☐ | Have extra support e.g. 1:1 at school | ☐ | ☐ |
| Manage money | ☐ | ☐ | When they do things (their routine) | ☐ | ☐ | Attend a day centre for people with Learning Disabilities | ☐ | ☐ |
| Carry out personal care | ☐ | ☐ | What you have said | ☐ | ☐ | Live(d) in a hospital or a home for people with learning disabilities | ☐ | ☐ |
| Tell the time | ☐ | ☐ | | | | Have people who support them (Carer/advocate) | ☐ | ☐ |
| Cook | ☐ | ☐ | | | | Manage in social situations | ☐ | ☐ |
| Have difficulty communicating with others | ☐ | ☐ | | | | | | |

**How does their learning disability impact on their health?**

**Medical History:**

**Diagnosis and any current medication:**

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| |
|---|
| **Past Medical History:** (Please include psychiatric history and recent hospital admissions if appropriate) |
| **Allergies:** (Please state if none, do not leave blank)<br>**Unknown** |

**Key People:**

| | | | |
|---|---|---|---|
| **Main Carer:** | | **Next of Kin:** | |
| Relationship: | | Relationship: | |
| Contact Details: | | Contact Details: | |

**Other Persons / Agencies involved in clients care:** (E.g. Social worker, day centre, health care professionals)

| Name | Role | Contact Details |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

**Risk Factors: (To clients and others)**

| |
|---|
| **Factors relevant to visiting:** (E.g. Times at home, religious commitments, pets) |
| **Risk to others or self** (E.g. violence, self-harm etc.) |

| **Consent: Consider Mental Capacity Act** | | | | | | |
|---|---|---|---|---|---|---|
| **Does the client consent to this referral?** | Yes | ☐ | No | ☐ | Does not have capacity to consent | ☐ |
| If person does not have capacity to consent to this referral please provide details as to how capacity was assessed, whether this referral was made in the person's best interests and who was involved in this process | | | | | | |
| **Does the client consent for their information to be shared with external agencies.** | Yes | ☐ | No | ☐ | Does not have capacity to consent | ☐ |

**Signature**

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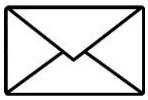
Referrers Signature:

**Please return via:**



**Post:** **Newham Health Team for People with Learning Disabilities**
**Unit 7 and 8 Stratford Office Village**
**Romford Road**
**Stratford**
**London**
**E15 4EA**

**Email: elt-tr.NewhamLD@nhs.net**

**For Internal Use Only**
Date Received: